

***FRAMEWORK FOR STATE EVALUATION
OF CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: _____ Texas

(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the
Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Don A. Gilbert

Commissioner

Texas Health and Human Services Commission

Date: March 30, 2000

Reporting Period: FY 1999

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

It is estimated that in September of 1999 Texas was covering between 30 to 35 percent of all low-income children ages 16 through 18 who qualified for health insurance coverage under Title XXI. These percents are based on analysis of preliminary enrollment data for that month, and which indicate that the number of children enrolled under Title XXI was likely to have fallen within the 31,000 to 41,000 range.

Based on the preliminary enrollment data, and on data from the March of 1999 Current Population Survey (CPS) for Texas, it is estimated that in September of 1999 the size of the ‘at-risk’ population for the Title XXI program may have fallen within the 106,000 to 116,000 range.

The estimated baseline number of uncovered low-income children ages 16 through 18 in September of 1999 is 75,000. This estimate represents the number of low-income uncovered children who were most likely to qualify for health insurance coverage under Title XXI only. Thus, this estimate does not include low-income uncovered children who were likely to qualify for regular Medicaid (Title XIX) through the TANF program.

In the HCFA 1998 Annual Report the estimate of low-income uncovered children for 1998 was 152,385. This figure is higher than the baseline estimate for September of 1999 due to these reasons:

- (1) The 152,385 included 15-year olds. The baseline estimate for September of 1999 excludes**

15-year olds. This exclusion caused a reduction in the total number of children the estimate for September of 1999 was drawn from.

- (2) The 152,385 estimate for 1998 included about 47,000 low-income uncovered children who were more likely to qualify for regular Medicaid through the TANF program. The estimate for September of 1999 does not include such group.**
- (3) The HCFA 1998 Annual Report estimate and the estimate for September of 1999 were extrapolated from March Current Population Survey (CPS) data. However, the estimate in the HCFA 1998 Annual Report was extrapolated using ‘pooled’ March 1997 and March 1998 CPS data, while the estimate for September of 1999 was extrapolated using March of 1999 CPS only. As it is generally known, the use of different versions of the March CPS can lead to variations in the size of any estimates, even when all other things are held constant. Additionally, CPS based estimates for small groups of the Texas population -- such as children ages 15 through 18 -- can become very unstable and may show abnormal year-to-year fluctuations that are reflections of poor, or inadequate, sample sizes. However, the bulk of the difference between the HCFA 1998 Annual Report estimate and the September 1999 estimate is attributed to having changed the way by which the group of low-income uncovered children more likely to qualify for coverage under Title XXI is defined.**

1.1.1 What are the data source(s) and methodology used to make this estimate?

The baseline estimate of low-income uncovered children for September of 1999 was done by extrapolating data from the March of 1999 Current Population Survey (CPS) for Texas. Variables included in the CPS such as age, health insurance coverage, poverty income level, and family characteristics were used to define the potential Title XXI eligibility status of children ages 16 through 18.

The September of 1999 baseline estimate represents uninsured children that according to the March of 1999 CPS met the following criteria: (1) Lived in TANF-type families with gross incomes between 76 and 100 percent of poverty, or; (2) Lived in Non-TANF type families with gross incomes of 100 percent of poverty or less.

For the purposes of this evaluation, TANF-type families were defined as those that according to the March of 1999 CPS met the following criteria: (1) They were headed by a single parent (with no spouse present) and had children, or; (2) Had two parents present, both parents were unemployed, and had children.

1.1.2 What is the State’s assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical

range or confidence intervals if available.)

The state regards the baseline estimate cited above as reliable, although this source may have a bias towards overestimating the rate of uninsurance for entire calendar year periods.

- 1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

The percent of children under the age of 19 with health insurance coverage has not changed significantly during the last two calendar years for which this type of information is available. It is estimated that 74.8 percent of Texas children under the age 19 had health insurance coverage of some sort during calendar year 1997, while the corresponding figure for calendar year 1998 was 74.1 percent. This means that during calendar years 1997 and 1998 the percent of uninsurance among children under the age of 19 remained essentially unchanged, at a little over 25 percent.

- 1.2.1 What are the data source(s) and methodology used to make this estimate?

The data on the percent of children insured / uninsured cited above were taken directly from the U.S. Census Bureau's March of 1998 and 1999 Current Population Surveys (CPS).

- 1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The state regards the data source on insurance coverage and uninsurance as moderately adequate, and it recognizes this source may have a bias towards overestimating the rate of uninsurance for entire calendar year periods.

- 1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use

additional pages as necessary. The table should be completed as follows:

- Column 1: List the State’s strategic objectives for the CHIP program, as specified in the State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		

Table 1.3

All necessary infrastructures for TEXAS CHIP PHASE I program are in place to accommodate enrollment, outreach, service provision, evaluation and monitoring of process and outcomes	By July 1, 1998, the systems for ongoing enrollment, provider recruitment, claims processing, outreach, evaluation and monitoring for Phase I will have been developed by expanding and enhancing current Medicaid activities as necessary	Performance goal met in time to successfully implement on July 1, 1998.
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OBJECTIVES RELATED TO CHIP ENROLLMENT

Previously uninsured children ages 15 through 18 will have access to quality health care through the TEXAS CHIP PHASE I program

As of September 30, 1999 35% of Children 16-18 years who are potentially eligible for Medicaid will be enrolled in the TEXAS CHIP PHASE I program

Data Sources: Demographic and eligibility data from the Research Department at the Texas Health and Human Services Commission.

Methodology: Divide the number of children 16-18 years of age that are Medicaid eligible into the number of children 16-18 years of age that are enrolled in Medicaid.

Numerator: The number of children 16-18 enrolled in Medicaid = 31,000-41,000.*

Denominator: The number of children 16-18 that are Medicaid eligible = 106,000-116,000.*

Progress Summary: The data indicates 29.6-35.3%* of Medicaid eligible children age 16-18 are enrolled in Medicaid. A substantial number of previously uninsured children have access to quality health care.

* Ranges reflect undercount due to systems errors identified this month. Final numbers will be submitted as soon as they are available.

OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)

Previously uninsured children ages 15 through 18 enrolled in the TEXAS CHIP PHASE I program have access to quality preventative and comprehensive diagnostic/treatment services by maximizing the use of primary prevention, early detection and management of health care via Texas Health Steps (THS) services.

During the fiscal year ending September 30, 1999 15% of all children 15-18 enrolled in the TEXAS CHIP PHASE I program will have had their THS (EPSDT) screens within periodicity.

Data Sources: Eligibility and Paid Claims data located on the Ad Hoc Query Platform

Methodology: Divide the unduplicated number of CHIP enrollees into the number of enrollees who had at least one screen during FY 1999.

Numerator: The number of enrollees who had at least one screen = 10,995

Denominator: The number of unduplicated enrollees = 58,286

Progress Summary: About 18.9% of CHIP enrollees had at least one screen during FY 1999. This indicates that CHIP enrollees have access to quality preventative and comprehensive diagnostic/treatment services.

OTHER OBJECTIVES

<p>Health care coverage will be expanded to children up to some level of income above 100% of the federal poverty level (Phase II) subject to the approval of the Governor and the Legislature</p>	<ol style="list-style-type: none"> 1. By January 1999, a proposed plan will have been developed to expand health care coverage to children up to some level of income above 100% of the federal poverty level (Phase II) subject to the approval of the Governor and the Legislature. 2. By September 1, 1999, health care coverage will be expanded by making insurance available to uninsured children up to some level of income above 100% of the federal poverty level, subject to the approval of the Governor and the Legislature. 	<ol style="list-style-type: none"> 1. The Texas Health and Human Services Commission and the Texas Department of Health on November 10, 1998 presented to legislative interim committees a plan to expand health care coverage to children. 2. Because enabling legislation enacted in May 1999 directed HHSC to implement an S-CHIP program completely separate and apart from the Medicaid infrastructure, implementation activities were ongoing at the conclusion of the period covered by this evaluation. CHIP Phase II will begin providing health care services to children with net family incomes up to 200% FPL May 1, 2000.
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SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

☒ Providing expanded eligibility under the State's Medicaid plan
(Medicaid CHIP expansion)

Name of program: **Medicaid**

Date enrollment began (i.e., when children first became eligible to receive services): **July 1, 1998**

☐ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: **CHIP**

Date enrollment began (i.e., when children first became eligible to receive services): **Enrollment begins April 3, 2000**

☐ Other - Family Coverage

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

☐ Other - Employer-sponsored Insurance Coverage

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

___ Other - Wraparound Benefit Package

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

___ Other (specify)

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

There have been no documented disruptive changes in the state's economy since July of 1998. The Texas economy has been growing during the last few years. The unemployment rate and the rate of overall price inflation have remained stable and very close to historical lows. In

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addition, the rate of poverty has declined.

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)? **Medicaid provided the most readily available means of reserving the state's 1998 allotment, a requirement which later was removed from the federal statute.**

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

___ No pre-existing programs were "State-only"

X One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP? **The Texas Healthy Kids Corporation (THKC) was created by the Texas Legislature and the Governor in 1997 to make affordable insurance coverage available to all uninsured children, using private donations to subsidize premiums for children up to 185% FPL and offering full-pay coverage for children in families with income above that level. THKC continues to enroll full-pay children. Those children on waiting lists due to the lack of premium subsidy dollars or health status as well as premium subsidy enrollees will be transitioned to the S-CHIP program after it becomes operational April 3, 2000.**

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

___ Changes to the Medicaid program

___ Presumptive eligibility for children

___ Coverage of Supplemental Security Income (SSI) children

___ Provision of continuous coverage (specify number of months ___)

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- ___ Elimination of assets tests
- ___ Elimination of face-to-face eligibility interviews
- ___ Easing of documentation requirements
- ___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____
- ___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance
- X** Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

More than 60 percent of Texans receive health insurance through their employer. In the past, when employers have been confronted with higher health insurance costs they have responded by shifting the costs to employees, dropping coverage or keeping wages stagnant. If health insurance costs continue to increase, some employers may begin to drop coverage, though the current tight labor market may forestall such an event.

The dramatic shift of employees from indemnity to managed care products that occurred in the 1990s appears to have peaked. This shift helped employers contain costs as managed care organizations competed vigorously for market share. In Texas, commercial HMO enrollment grew from 1,750,000 members in 1994 to nearly 4 million members by the end of 1999. (see Allan Baumgarten, *Texas Managed Care Review-1998*; Texas Department of Insurance, 1999 Annual Report—Part 1). Evidence suggests, however, that the competition in Texas may have compelled HMOs to set premium rates at artificially low levels. Through 14 consecutive quarters ending in Fiscal Year 1999, Texas HMOs had lost a combined \$1.15 billion. (see Texas Department of Insurance, 1999 Annual Report—Part 1).

During the last two years, health benefit costs for employers have begun to rise at an accelerating rate. Nationally, employers reported a 6.2% increase in 1998 and a 7.2% increase in 1999. Costs are expected to rise 7.5% in 2000. (see William M. Mercer, News Release, “Passing Health Plan Cost Increases to Employees Not An Option for Firms Struggling with Labor Shortages (Dec. 14, 1999). Though Texas cost increases are typically lower than the national average (4% versus 6.2% in 1998, for example), anecdotal reports from the state Employee Retirement System (ERS) and the Texas Healthy Kids Corporation

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suggest that managed care and other health insurance plans will be seeking substantial premium increases as contracts come up for renewal.

Should the economy remain strong and the labor market tight, employers may continue to absorb health benefit cost increases. If the economy weakens, employers may adopt measures used in the past to control their costs, including eliminating some health benefits, shifting cost-sharing to employees, freezing wages, or dropping coverage.

- ___ Changes in the delivery system
 - ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
 - ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
 - ___ Other (specify) _____
- ___ Development of new health care programs or services for targeted low-income children (specify)

- ___ Changes in the demographic or socioeconomic context
 - ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____
 - ___ Changes in economic circumstances, such as unemployment rate (specify) _____
 - ___ X Other (specify) _____
 - ___ Other (specify) _____

In regard to changes in demographic structure, the state's population has continued to grow during the last few years and is becoming increasingly racially and ethnically diverse. Like in other areas of the nation, the state's population is getting slightly older. These changes in demographic structure, though, have followed the course predicted by demographers at the U.S. Census Bureau and the Texas State Data Center.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

- 3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

Table 3.1.1			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____ _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide		
Age	6 through 18		
Income (define countable income)	Less than 100% of FPIL. Exclude adoption subsidy, educational assistance, foster care payments, government housing assistance, in-kind income, loans, some government payments, reimbursements, SSI. Deduct up to \$120 work related expense, dependent care costs up to \$175-200, alimony, payments to dependents living outside the home, child support payments, up to \$50 child support disregard.		

Resources (including any standards relating to spend downs and disposition of resources)	Less than \$2000. Exclude value of primary vehicle, additional vehicles exempt up to \$4650. Transfer of resources penalty does not apply.		
Residency requirements	Intent to remain in Texas—a permanent residence is not required.		
Disability status	N/A		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	Title XIX (Medicaid) funds are to be used for payment only after all available third-party resources have been used.		
Other standards (identify and describe)	Social Security Number—certified child must provide or apply for a social security number. Citizenship—Undocumented aliens, non-immigrants, and certain legal permanent resident aliens are not eligible (I-551 admitted on or after 8/22/96).		

**Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* ----- —
Monthly			
Every six months	X		
Every twelve months			
Other (specify)			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ☐ Which program(s)?

For how long?

_X No

3.1.4 Does the CHIP program provide retroactive eligibility?

X Yes ☐ Which program(s)?

How many months look-back? **_3**

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

_ Yes ☐ Which program(s)?

Which populations?

Who determines?

_X No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

☒ Yes ^o Is the joint application used to determine eligibility for other State programs? If yes, specify. **Because the state's CHIP program in operation during the period covered by this report was a Medicaid expansion, the application is identical to that for the rest of the Medicaid program. The state's S-CHIP program to be implemented April 3, 2000 includes a joint application for S-CHIP, Medicaid, and Texas Healthy Kids Corporation.**

☐ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children **The eligibility determination process for that portion of the state's CHIP program in operation during the period covered by this report is linked to the eligibility processes for TANF and food stamps. As such, it is not designed strictly for purposes of increasing creditable health coverage among targeted low-income children. The generic worksheet instead is designed to maximize access of eligible individuals to the services provided by all three programs.**

A state agency workgroup with consumer representation currently is reviewing eligibility determination and redetermination processes to identify steps that can be taken to improve those processes. Policy issues are under consideration as well.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process? **The strengths of the current eligibility redetermination process are that it ensures the client understands the information that is provided and it doesn't rely on the mail for the application and to obtain information which can cause delays in determining eligibility.**

3.2 What benefits do children receive and how is the delivery system structured?
(Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing

which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type_Medicaid Expansion			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T		
Outpatient hospital services	T		
Physician services	T		
Clinic services	T		
Prescription drugs	T		
Over-the-counter medications			
Outpatient laboratory and radiology services	T		
Prenatal care	T		
Family planning services	T		
Inpatient mental health services	T		Must be prior-authorized for initial and continued stays
Outpatient mental health services	T		Limited to 30 visits per calendar year prior-authorized if more is needed
Inpatient substance abuse treatment services			
Residential substance abuse treatment services			
Outpatient substance abuse treatment services	T		Only by duly enrolled providers
Durable medical equipment	T		
Disposable medical supplies	T		

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Preventive dental services	T		
Restorative dental services	T		
Hearing screening	T		
Hearing aids	T		
Vision screening	T		
Corrective lenses (including eyeglasses)	T		
Developmental assessment	T		
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		Physician prescribed
Speech therapy	T		Physician prescribed
Occupational therapy	T		Physician prescribed
Physical rehabilitation services	T		
Podiatric services	T		
Chiropractic services	T		
Medical transportation	T		Must be prior-authorized

Home health services	T		
Nursing facility			
ICF/MR	T		Operating agency not TDH
Hospice care	T		
Private duty nursing	T		
Personal care services	T		
Habilitative services			
Case management/Care coordination	T		
Non-emergency transportation	T		Must be prior-authorized
Interpreter services			
Other (Specify)			
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Services are identical to the state's normal Medicaid fee for service array for all children under 21. There is no cost sharing. Preventive services and services to children with special health care needs are identical to those provided to all Medicaid eligible children. Enabling services such as non-emergency transportation, home visits, and outreach are part of the array of services provided. Case management is offered as well.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)	X (in certain parts of the state)		—
Statewide?	___ Yes X No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs			

B. Primary care case management (PCCM) program	X (in certain parts of the state)		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	X (in certain parts of the state)		
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.3 How much does CHIP cost families?

- 3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

☒ **No, skip to section 3.4 Cost-sharing on a sliding scale basis will be required of families with children enrolled in Texas’ S-CHIP program to be implemented April 3, 2000.**

☐ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____

Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments* *			
Other (specify) _____			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

- ___ Employer
- ___ Family
- ___ Absent parent
- ___ Private donations/sponsorship
- ___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing

does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

- ____ Shoebox method (families save records documenting cumulative level of cost sharing)
- ____ Health plan administration (health plans track cumulative level of cost sharing)
- ____ Audit and reconciliation (State performs audit of utilization and cost sharing)
- ____ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program (to be implemented April 3, 2000)		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards						
Brochures/flyers	T	3	T			
Direct mail by State/enrollment broker/administrative contractor	T	3	T			
Education sessions	T	3	T			
Home visits by State/enrollment broker/administrative contractor						
Hotline	T	2	T			
Incentives for education/outreach staff	T	1	T			
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	T	4	T			
Prime-time TV advertisements	T	4	T			
Public access cable TV	T	3	T			
Public transportation ads			T			

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Radio/newspaper/TV advertisement and PSAs	T	3	T			
Signs/posters	T	4	T			
State/broker initiated phone calls						
Other (specify)___ Telethons			T			
Other (specify)___ Contracted community-based organizations (CBOs)			T			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program (to be implemented April 3, 2000)		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	T	4	T			
Beneficiary's home						
Day care centers			T			
Faith communities	T	4	T			
Fast food restaurants			T			
Grocery stores			T			
Homeless shelters			T			
Job training centers			T			
Laundromats						
Libraries	T	3	T			
Local/community health centers	T	4	T			
Point of service/provider locations	T	4	T			
Public meetings/health fairs	T	4	T			

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Public housing			T			
Refugee resettlement programs	T	4	T			
Schools/adult education sites	T	4	T			
Senior centers			T			
Social service agency	T	4	T			
Workplace						
Other (specify)						
Other (specify)						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

- 3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

In order to evaluate the effectiveness of the outreach effort the following measures were utilized: individual contacts with consumers, number of community based agencies addressed, number of participants in CHIP Phase I training, documentation of outreach methods used and their effectiveness, and the average monthly number of Medicaid recipients found eligible under CHIP Phase I.

- 3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

All creative materials such as fliers, posters, brochures, TV and radio messages were in English and Spanish. In addition, ethnic media such as radio, television and print was utilized to reach the Spanish speaking market. In South Texas, *promotoras* were trained on CHIP Phase I and utilized door to door canvassing to conduct outreach activities in their local communities.

- 3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

As found in other states, grassroots outreach appears to be the most effective. Consumers that have had negative experiences with health insurance or have been denied for Medicaid in the past meet the news of CHIP with cautious enthusiasm. Consumers have many questions they want answered prior to applying and the trusted individuals from their communities are one of the best sources for that information. This is especially true for immigrants who are concerned that applying for health insurance will negatively affect their immigration status. Texas found that immigration attorneys are a valuable resource and often what they say has a tremendous impact upon the immigrant population. This same methodology is the basis for outreach conducted by *promotoras*,

who are trusted individuals in the community and often friends and neighbors of the consumers.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) **See list below	Other (specify) _____
Administration				
Outreach		X	X	
Eligibility determination		X		
Service delivery				
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify)				
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

**** Local public health clinics; hospitals and hospital districts; Head Start centers; public health nurses; social workers; WIC clinics; Title V contractors for maternal health, child health, and children with special health care needs; field offices of the Texas Workforce Commission; Salvation Army and other shelters; publicly funded day care centers; local food pantries; churches operating programs to assist those leaving cash assistance and other low-income families; other community-based social service and advocacy entities; organizations working with migrant**

farm workers; and tribal organizations.

The TEXAS CHIP PHASE I Program utilizes the existing Medicaid eligibility and referral structure to identify and enroll children who are eligible under the new State Title XXI Medicaid category. That structure was augmented with the addition of TDHS eligibility staff.

Eligibility workers in field offices and at outstation locations were be notified of the new eligibility category, as were the following programs and entities that serve the target population and make referrals to Medicaid:

Outstationed Eligibility Staff - TDHS outstations eligibility workers in clinics and hospitals. These staff perform eligibility functions as well as screening functions for potential Medicaid eligibles. There are approximately 300 staff outstationed in 190 facilities. The number of outstationed eligibility staff in a facility is a function of the volume of eligibility determinations made at the facility. In some cases, disproportionate share hospitals (DSH) and Federally Qualified Health Centers (FQHCs) fund the state share of salary and benefits costs associated with staff above and beyond those required by federal law. Facilities that are not DSH hospitals or FQHCs can contract with TDHS for eligibility specialists and appropriate support staff to be placed in the facility. Under these contracts, the facilities also reimburse TDHS for the state share of the employee's salary and benefits.

TDHS Hotline (1-800-252-9330) - The Hotline primarily handles complaints. However, when a client calls and relays information about potential eligibility, or inquires about programs for which they may be eligible, the client is referred to the correct local office or, if appropriate, to a designated regional contact.

TDHS Administrative Services (512-438-3280) - Clients and potential clients who call TDHS State Office are referred to the administrative services unit. Some of these calls may be from potential clients asking for instructions/assistance in applying for benefits. Callers are referred to local TDHS offices as appropriate.

Blue Pages Listings - Current information for local TDHS offices is contained in local telephone directories in the government blue pages section. This information is broken down by programs and is updated as needed.

Worldwide Web Sites - TDHS maintains an agency home page that contains information about what types of benefits are available throughout the agency and also contains links to home pages for each of the TDHS regions. The regional home pages contain listings of local offices, and the services available at each of the local offices.

Food Stamps – Individuals applying for food stamps are tested for eligibility for Medicaid during the same interview.

Temporary Assistance to Needy Families (TANF) – Individuals eligible for TANF are made Medicaid eligible by virtue of their certification for TANF. Those who apply and are determined ineligible for TANF are tested to determine their eligibility for Medicaid under other eligibility categories. Former TANF recipients receiving transitional Medicaid are sent an automated notice telling them to contact their local TDHS office if they wish to reapply for Medicaid when the transitional Medicaid ends.

Newborns of Medicaid Eligible Mothers - Enrollment in Medicaid is automatic for the majority of newborns of Medicaid-eligible mothers. When the medical facility notifies a TDHS centralized unit about the birth of the child to a Medicaid-eligible mother, the TDHS unit establishes eligibility for the child. An automated system then notifies the child's mother, designated providers, and the child mother's caseworker about the child's eligibility. These newborn children are also included in the Texas Health Steps outreach (see below).

Title V - In the Texas Title V Children with Special Health Care Needs (CSHCN) program, known as the Chronically Ill and Disabled Children's Services Program (CIDC), all clients are required to apply to Medicaid before they receive full CIDC eligibility. Some are enrolled in Medicaid as a result. Those who reach a certain expenditure level for CIDC services are required to apply again to Medicaid, with the emphasis on eligibility for the Medicaid Medically Needy Program, the spenddown program under Title XIX.

The regional Title V CIDC social work and eligibility staff and the CIDC case management contractors help families with CSHCN to obtain Medicaid eligibility when appropriate.

In Title V Maternal/Child Health (MCH) contracts across the state, children who, after eligibility screening, appear to be eligible for Medicaid, are required to apply for Medicaid in order to continue to receive MCH services in the contractors' clinics. The contractors include many local health departments as well as hospital districts and other providers. An automated screening tool, Texas Eligibility Screening System (TESS), is used by many of these providers to screen for possible eligibility for Medicaid, CIDC, and other programs. The client must then go on to actual Medicaid eligibility determination, if the TESS screen indicates they may be Medicaid eligible.

Supplemental Security Income - SSI eligible persons are automatically enrolled in Medicaid in Texas. The Texas Rehabilitation Commission Disability Determination Divisions make disability determinations for SSI.

Foster Care - For children who are removed from their households by court order through the Texas Department of Protective and Regulatory Services (TDPRS), Medicaid is provided through foster care if the child was eligible for Medicaid prior to being removed from the household or if the child is determined to be Medicaid eligible by TDPRS standards. Medicaid

is also provided, under Medically Needy and TANF limits, to children under 18 placed by a district court in the managing conservatorship of TDPRS as a result of findings of abuse or neglect by TDPRS.

Child Support - The Child Support Enforcement Office of the Attorney General seeks out the non-custodial parent for financial and/or medical support to supplement and/or replace state liability. This office also processes through the Third Party Reimbursement (TPR) system to seek premium reimbursement for cases where medical coverage is provided.

Local Mental Health Authorities (LMHAs) - Under the authority of the Texas Department of Mental Health and Mental Retardation, LMHAs are required to do outreach to identify clients with serious mental illness and mental retardation. The LMHAs vary in the amount and types of outreach conducted. Outreach activities may include: public announcements; distribution of brochures in targeted areas, such as doctors' offices, schools, and juvenile courts; public forums; or public festivals.

At intake, information which may indicate Medicaid eligibility is gathered by the LMHA. Individuals who appear to be Medicaid eligible are then referred for Medicaid eligibility determination. If the individual needs assistance with this referral, the LMHA will assist.

LMHAs may have outstationed TDHS Medicaid eligibility workers on staff who do the Medicaid eligibility determinations on site.

Texas Health Steps - Texas also connects children with the Medicaid eligibility determination process through Texas Health Steps (THSteps), Texas' EPSDT program. Families with potentially eligible children are referred to local TDHS Medicaid eligibility offices.

Texas Health Steps outreach efforts are aimed at encouraging use of services (program participation) by enrolled THSteps clients. Texas Health Steps communicates with Medicaid eligible families on the state level as well as on the regional and local level through a statewide system of TDH staff and contractors using the following tools:

- over 435,000 informing letters per month;
- a variety of brochures and other handouts in English and Spanish for recipient and provider use;
- home visits, outreach at places where clients may be found, and efforts targeting specific groups such as migrant workers and newly enrolled Medicaid recipients;
- at least one toll-free number for Health Steps information; some regions with large outreach contractors have more than one toll-free number;

- regional provider newsletters which help to keep Health Steps providers informed of developments in the program;
- regional provider relations staff who help recruit and maintain Health Steps and Medicaid providers, supplementing the provider relations activities for which TDH contracts with NHIC;
- the Medicaid Bulletin, which provides information to all Medicaid providers; and
- the Medicaid managed care enrollment broker, whose staff helps educate clients as they are enrolled in health plans;

Babylove Line - The Babylove toll-free hotline, funded by Title V, provides information and referrals for families who call in, including referrals to Medicaid and Title V MCH and CIDC services.

Texas Information and Referral Network – The Texas Information and Referral Network (TIRN) at the Health and Human Services commission, coordinates a statewide network of state and local contact points to provide information regarding health and human services in Texas, including Medicaid.

Information on the new TEXAS CHIP PHASE I Program also was provided to the following public/private partnerships:

- The **Texas Insurance Purchasing Alliance (TIPA)** which closed its doors in July 1999 made health coverage available through a purchasing cooperative to small employers who in turn were able to offer coverage to their employees and their dependents, including children who were not otherwise covered. Dependent coverage had been offered as a part of any coverage once offered by the employer. TIPA was a non-profit corporate cooperative of small employers and their employees created by the Texas legislature in 1993 to bring group purchasing power to the small employer health insurance market.
- The **Caring for Children Foundation of Texas, Inc.** provides a package of health care benefits for uninsured children ages 6 to 18 who are enrolled in school with family incomes up to 133 percent of the federal poverty level. Children must have applied for but been denied Medicaid coverage within the previous three months. Service costs are funded by donations from companies, religious groups, community and civic organizations, employee groups, and individuals. Administrative and operating costs

are paid by Blue Cross Blue Shield of Texas, Inc. Benefits include doctor visits, routine immunizations, outpatient diagnostic tests, outpatient surgery, outpatient emergency illness and accident care, and prescription drugs. There are no costs to the family except for a \$5.00 co-pay for each prescription drug.

- The Laredo Project is a school-based pilot health insurance program created by the Texas Legislature in 1995 to cover uninsured children up to age 13 with family incomes up to 133 percent of the federal poverty level who are not eligible for Medicaid. A local elementary school in Laredo, Texas, was the initial site chosen for the pilot. The project has been expanded to include the entire Laredo Independent School District and the United Independent School District.

The pilot provides low-cost comprehensive coverage and has been in operation for one year. Currently 500 children are enrolled. At least 20 percent of those screened during the first year were found eligible for and enrolled in Medicaid.

- The Texas Health Insurance Risk Pool was funded by the Texas legislature in 1997 to provide the administrative structure for ensuring that health coverage is available to persons unable to otherwise obtain coverage because of their medical history or because they lose employer coverage. Coverage is automatic for persons with certain diagnoses, such as metastatic cancer, leukemia, diabetes, epilepsy, and sickle cell anemia. The pool began operation on January 1, 1998.
- The Community Access To Child Health (CATCH) The CATCH Program is a program of the American Academy of Pediatrics funded by the dues of AAP members. There are also funds for CATCH planning meetings at the chapter level nationwide, which are supported by physician donations to the Friends of Children Fund and by funds from Wyeth Lederle Laboratories. The purpose of the CATCH program is to assist public-private partnerships in local communities to identify and resolve local problems of children's access to health care. Projects include providing health care services for children living in the *colonias* (rural developments along the Texas-Mexico border which frequently may not have basic amenities such as running water) and case management for very low birth weight babies.
- The Healthy Tomorrows Partnership for Children Program is a collaborative grant of the federal Maternal and Child Health Bureau and the American Academy of Pediatrics for local entities, such as local health departments, county hospital districts, and community health centers that are supported in part with state funds to increase access of mothers and children to health services. Projects include providing direct health care, prevention of sexually transmitted disease among minority youth, and

improving the health status of medically indigent, low birth weight infants.

- Two public programs identify children who could benefit from a private-public partnership. The Texas Medicaid program through the Health Insurance Premium Payment Program (HIPP) pays health insurance premiums for Medicaid eligible children. HIPP works with other state agencies, private employers, and private health coverage providers to ensure that Medicaid eligible children are able to take advantage of health coverage to which they have access. Given the broader scope of Medicaid benefits relative to the typical defined benefits package, children are able to take advantage of both public and private resources in receiving the services they need.
- The Texas Title V program for children with special health care needs (CSHCN), the Chronically Ill and Disabled Children's Services program (CIDC), has a similar program in which it pays private health coverage premiums, when doing so is cost effective for CIDC and when the family is unable to afford the premiums. This program serves children with family incomes up to 200% of the federal poverty level.
- In May, 1997, the Texas legislature created the Texas Healthy Kids Corporation (THKC), a non-profit corporation, as the administrative structure for designing and implementing a health insurance program for uninsured children up to age 18 in Texas. THKC will design a benefit package; determine eligibility requirements for private health coverage providers (e.g., health insurance plans and health maintenance organizations), which in turn will bid to participate in the THKC Program; and contract with approved private health coverage providers to offer coverage for uninsured children. The 1997 legislation also authorized Texas courts to designate THKC plans under medical support provisions of child support orders. THKC may develop a premium structure based on ability to pay for low income uninsured children, but THKC plans will be offered to all uninsured children at all income levels.

Outreach efforts to families of children likely to be eligible for the new State Title XXI program also were carried out in conjunction with Texas' EPSDT program, Texas Health Steps, and its Title V program (see 2.2.1 above). Those existing efforts were refined to also target the TEXAS CHIP PHASE I population.

In the course of promoting the utilization of EPSDT services, Texas Health Steps staff and contractors informed families of the accelerated eligibility for teens and of the process for determining eligibility. As they followed up with those families in relation to younger children, they continued to encourage the families to pursue Medicaid enrollment for older siblings.

Texas Department of Health Title V staff and TDHS eligibility policy staff developed

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informational materials and methods of delivery that were appropriate to adolescents and their parents. Those materials explaining the new program and the eligibility process were made available to families with potentially eligible teens through a variety of distribution points, including: local public health clinics; hospitals and hospital districts; Head Start centers; public health nurses; social workers; WIC clinics; Title V contractors for maternal health, child health, and children with special health care needs; field offices of the Texas Workforce Commission; Salvation Army and other shelters; publicly funded day care centers; local food pantries; churches operating programs to assist those leaving cash assistance and other low-income families; other community-based social service and advocacy entities; organizations working with migrant farm workers; and tribal organizations. Information on the new accelerated eligibility for teens also was made available to parent-teacher associations and to independent school districts solely for use at their discretion.

Appropriate materials were distributed to all Medicaid providers both directly and through a coordinated effort with provider professional associations advising them of the new eligibility group.

Some state funded public health programs, such as Texas' program for children with special health care needs known as CIDC, require applicants to pursue Medicaid eligibility before accessing services through those programs. Older teens in those programs were assisted in applying for Medicaid under the new eligibility category.

Targeted mailings were sent to those families of otherwise Medicaid eligible children where state eligibility records indicated the presence of a currently ineligible older teen who might qualify under the new TEXAS CHIP PHASE I Program.

3.6 How do you avoid crowd-out of private insurance?

The CHIP Medicaid expansion allows clients to retain their private insurance. Therefore crowdout is not an issue. Six percent of Phase I CHIP enrollees were covered by their private insurance which was primary to the CHIP Medicaid expansion.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Specific anti-crowdout policies implemented in the CHIP Medicaid expansion were those used generally in the Medicaid program. Anti-crowdout policies implemented in the S-CHIP program beginning April 3, 2000 will include benefits package design and a 90-day waiting period without health insurance.

___ Eligibility determination process:

- ___ Waiting period without health insurance (specify)
- ___ Information on current or previous health insurance gathered on application (specify)
- ___ Information verified with employer (specify)
- ___ Records match (specify)
- ___ Other (specify)
- ___ Other (specify)

___ Benefit package design:

- ___ Benefit limits (specify)
- ___ Cost-sharing (specify)
- ___ Other (specify)
- ___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

- ___ Other (specify)
- ___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Crowdout in the CHIP Medicaid expansion was monitored through the third party recovery program.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 4.1.1 CHIP Program Type Medicaid expansion to U3s						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children						
Age						
Under 1						
1-5						
6-12						
13-18	25,176	50,878	2.2	7.9	370	18,287

Countable Income Level*						
At or below 150% FPL	25,176	50,878	2.2	7.9	370	18,287
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						
13-18						
At or below 150% FPL	25,176	50,878	2.2	7.9	370	18,287
Above 150% FPL						
Type of plan						
Fee-for-service	22,677	44,097	2.1	8.5	370	13523
Managed care	1,780	4832	2.4	4.3		3,436
PCCM	719	1,949	2.5	4.3		18,287

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

- 4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i)) **No data available**
 - 4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C)) **Other private programs in the state have enrolled some 14,000 children, between the Caring for Children program and the Texas Healthy Kids Corporation. With the implementation of S-CHIP the Corporation is determining how best to reach families with income above the S-CHIP level and provide those families the opportunity to purchase health insurance coverage through the Corporation.**
- 4.2 Who disenrolled from your CHIP program and why?
- 4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?
 - 4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

At renewal, 11.0% (5,454 of 49,403) of children did not re-enroll. This covers all renewals for cases with CHIP Expansion children for July 1998 (implementation of CHIP Expansion in Texas) through September 1999.

We are unable to completely determine the number of children who got other coverage when they left CHIP, if they did not re-enroll at renewal. Table 4.2.3 shows that 238 children transferred to Medicaid following disenrollment from CHIP. However, these only account for children in a case that transferred to Medicaid. In addition, they include disenrollments that are prior to the regular renewal period. We believe that we have not tracked some children that enrolled in Medicaid because of changes in the case number on automated systems. We will continue to investigate this and will submit a revision if the numbers change.

- 4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Data sources:

Files and inquiry from the Texas Department of Human Services case and client data base (SAVERR):

File number TT*TT307420C (created 31 December 1999): Medicaid clients enrolled in the last 3 years and their 10 most recent Medicaid spells;

File number TP400214C: monthly file of case-level transactions for public assistance cases.

Methodology:

CHIP Expansion spells occurring from July 1998 through September 1999 were analyzed for discontinuation. A CHIP Expansion discontinuation is defined as a break of one or more months of receipt of CHIP Expansion. The CHIP Expansion discontinuations are duplicated by child, i.e., a child could contribute more than one CHIP Expansion discontinuation.

A three-step process was used to determine the reason for a CHIP Expansion discontinuation. The first step was to determine if the child turned 19 years old in the month of CHIP Expansion discontinuation. If so, ‘Aged out of program’ was the reason for the CHIP Expansion discontinuation. The second step was to match the discontinued child’s Medicaid case number to monthly files of Medicaid case-level transactions (case openings, closings, transfers, benefit changes, etc) to determine the cause of CHIP Expansion discontinuation. Each of these transactions has a reason associated with it. For the third step, for those CHIP Expansion discontinuations with no reason determined by the first two steps, samples were drawn to manually research the reason for discontinuation. The second and third steps are more fully explained below.

The cases of the children whose CHIP Expansion spells discontinued in July 1999 through September 1999 were matched to monthly files containing Medicaid case-level transactions to determine the cause of the discontinuation of the child’s CHIP Expansion spell. If the child discontinued CHIP Expansion at the end of a month, matches to that month’s and the next month’s Medicaid case-level transaction files were done. Very often, there was a change in the child’s case number when the child discontinued CHIP Expansion to transfer to other Medicaid coverage. In that case, there would be no match between the child’s new case number and the Medicaid case-level transaction record for the original CHIP Expansion case number.

In addition, if the child’s CHIP Expansion spell discontinued but no case-level transaction occurred, no Medicaid case-level transaction record was generated with the reason for the child’s CHIP Expansion discontinuation. In Texas, CHIP Expansion children can be included on a Medicaid case with other children who are enrolled in another Medicaid plan. This other

Medicaid plan is for children age 6 or older born October 1, 1983 or later. This multi-client case arrangement results in CHIP Expansion client discontinuations not generating a case-level transaction.

For the CHIP Expansion discontinuations for which no matching case-level transaction could be found, a sample of 50 was drawn from the CHIP Expansion discontinuations occurring in September 1998, December 1998, March 1999, June 1999 and September 1999 (the last month of each FFY quarter). The sample from each of the 5 months was then researched by direct inquiry of the Texas Department of Human Services case and client data base (SAVERR). SAVERR contains current and some historical data. The proportion of each discontinuation reason for the combined sample of 250 CHIP Expansion discontinuations was determined. The proportions for the discontinuation reasons were applied to the CHIP Expansion discontinuations for which 'Aged out of program' or reason from a match to the Medicaid monthly transactions file were not found.

The CHIP Expansion discontinuations with known reasons for discontinuation and the discontinuations with sample proportions of reasons for discontinuation were combined for Table 4.2.3. Percentages may not add to 100 due to rounding.

In Table 4.2.3., it is unknown if children who discontinue CHIP Expansion have access to commercial insurance. In addition, there is no premium required for CHIP Expansion, so 'Nonpayment of premium' is not applicable.

Reporting period:

The period covered is from CHIP expansion Medicaid implementation in July 1998 through September 1999 (partial FFY 98 and all of FFY 99).

Table 4.2.3						
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	31,713	100				
Access to commercial insurance	Unknown*	Unknown*				
Eligible for Medicaid	238	0.8				
Income too high	5,520	17.4				

Aged out of program	2,941	9.3				
Moved/died	377	1.2				
Nonpayment of premium	N/A*	N/A*				
Incomplete documentation	7,367	23.2				
Did not reply/unable to contact	4,938	15.6				
Other (specify) Removed from case, reason not specified	3,160	10.0				
Other (specify) Other eligibility requirements unmet	2,400	7.6				
Other (specify) Fewer members in certified group	38	0.1				
Other (specify) No eligible child	499	1.6				
Other (specify) Voluntary withdrawal	1,537	4.8				
Don't know	2,698	8.5				

*** Unknown and not applicable (n/a): see Methodology section.**

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll? **When a case is denied for a reason that does not cause Medicaid ineligibility, staff determines what Medical Program applies to each household member. If all eligibility requirements are met, each eligible child is certified on the appropriate Medical program.**

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 **\$3,008,282**

FFY 1999 **\$81,635,119**

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

See attached spreadsheet.

Table 4.3.1 CHIP Program Type Medicaid expansion to U3s				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures				
Premiums for private health insurance (net of cost-sharing offsets)*				
Fee-for-service expenditures (subtotal)				
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				

Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? **Eligibility determinations and automation**

What role did the 10 percent cap have in program design? **The 10% cap will affect program design and method of finance for the S-CHIP program which becomes operational on April 3, 2000.**

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration	45,246	5,222,453				
Other _____						
Federal share						
Outreach						
Administration	33,301	3,848,263				
Other _____						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- ☒ State appropriations
- ___ County/local funds
- ___ Employer contributions
- ___ Foundation grants
- ___ Private donations (such as United Way, sponsorship)
- ___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

- 4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Appointment audits			
PCP/enrollee ratios	MCO** PCCM*		
Time/distance standards	MCO** PCCM		
Urgent/routine care access standards	MCO** PCCM		
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO** PCCM*		
Complaint/grievance/disenrollment reviews	MCO** PCCM		
Case file reviews	MCO*** PCCM		
Beneficiary surveys	MCO*** PCCM		
Utilization analysis (emergency room use, preventive care use)	MCO**** PCCM		

* Provider ratios have been dropped for PCCM; PCCM network does not include specialists

** The Bureau of Medicaid Managed Care does not separate the Medicaid expansion group (age 15-18) from the general Medicaid population.

*** The Texas EQRO conducts medical record reviews as part of their quality review and also conducts member satisfaction surveys.

**** The Bureau of Managed Care receives semi-annual aggregate utilization management reports from the HMOs.

Other (specify) _____			
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*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	<input checked="" type="checkbox"/> ¹ Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requiring submission of aggregate HEDIS data by health plans	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (specify) Semi-annual aggregate reports of utilization data for HEDIS-like measures	<input checked="" type="checkbox"/> ² Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

See attached managed care report.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

See attached managed care report.

4.5 How are you measuring the quality of care received by CHIP enrollees?

See the attached managed care waiver excerpt.

¹ The bureau of Medicaid managed care does not measure the Medicaid expansion (15-18 year olds) separately from the remainder of the Medicaid managed care population.

² The bureau receives semi-annual aggregate reports of utilization data for HEDIS like measurements.

- 4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in primary care case management, specify ‘PCCM.’

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	MCOs³ PCCM		
Client satisfaction surveys	MCOs³ PCCM		
Complaint/grievance/disenrollment reviews	MCOs³ PCCM		
Sentinel event reviews			
Plan site visits	MCOs³ PCCM		
Case file reviews			
Independent peer review			
HEDIS performance measurement	MCOs⁴ PCCM		
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			

- 4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Data are included in the attached managed care report.

- 4.5.3 What plans does your CHIP program have for future monitoring/evaluation of

³ The bureau of Medicaid managed care does not separate out Medicaid expansion (15-18 year olds) in its program’s processes at this time.

⁴ The bureau of Medicaid managed care uses utilization data for HEDIS like performance measurements and does not separate out Medicaid expansion (15-18 year olds) in its program’s processes at this time.

quality of care received by CHIP enrollees? When will data be available?

The CHIP eligible Phase I children enrolled in the Medicaid Managed Care (MMC) program have the same quality of care information as the 1915(b) waiver program recipients. This includes member satisfaction survey results, focused studies, complaint information received on a quarterly basis for the Managed Care Organizations (MCOs) and incorporated in annual reports on quality improvement. The MCO quality improvement plans follow contractually required use of the HCFA XVI Quality Assurance guidelines.

- 4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

There are numerous Texas Health Quality Alliance (THQA) reports and most of the reports are voluminous. A draft Medicaid Managed Care Annual Report is attached and is a summary of the various THQA reports and other source documents. The separate THQA reports will be provided upon request.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

- 5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

- 5.1.1 Eligibility Determination/Redetermination and Enrollment

N/A

- 5.1.2 Outreach

The state is implementing its S-CHIP program on April 3, 2000. Through the CHIP Medicaid expansion the state did learn that dissemination of information is not enough to guarantee that consumers will apply for health insurance. A multi-faceted outreach

effort needs to be utilized. Media mainly serves as a vehicle for program awareness and a call to action to apply. Meanwhile, grassroots outreach efforts including application assistance is the most effective way to ensure consumers will apply for health insurance. In the S-CHIP program, the state will evaluate the effectiveness of their outreach efforts by tracking the contracted community-based organizations' application assistance. The state will be able to determine the outcome if each application and evaluate the effectiveness of the CBOs' outreach strategies.

- 5.1.3 Benefit Structure **N/A**
- 5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)
- 5.1.5 Delivery System **N/A**
- 5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)
- 5.1.7 Evaluation and Monitoring (including data reporting) **N/A**
- 5.1.8 Other (specify)
- 5.2 What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))
- 5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

IV. ACCESS TO CARE AND QUALITY OF SERVICES:

- A. **General:** A 1915(b)(1) waiver program serves to improve a client's access to quality medical services. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency and family planning services must not be restricted.
- B. **Complaint Process:** What process will be in place to handle complaints under the Waiver program; e.g., a HelpLine. How will this compare to the regular Medicaid program? **NOTE: Members must have available and be informed of a formal appeals process under 42 CFR Part 431, Subpart E which may lead to a Fair Hearing.** Please fully describe.

In the traditional Texas Medicaid program, clients have access to the TDH Fair Hearing process as afforded under 42 CFR Part 431, Subpart E. At any time, a managed care client may request a Fair Hearing in writing or through the State's Medicaid hotline. In addition to access to the TDH Fair Hearing process, STAR Members also have access to the plans' internal complaint processes. The HMOs are required to maintain at least one local and one toll-free telephone number for making complaints (See Articles 8.6 and 8.7 of the HMO contract). In addition, the HMOs are required to provide Member representatives to assist Members and making Members aware of their rights and responsibilities, the complaint process, the health education and prevention activities available to them. The complaint process requirements identified in Article 8.6 of the HMO contract applies to all participating plans, including the State's PCCM plan.

In the STAR program, Members are informed through the Member Handbook, which Members receive after enrollment, of their right to a TDH fair hearing, the plans' toll-free hotlines, and the plans' internal complaint process. Members (and HMOs) are informed that at all times the Member retains the right to request a TDH fair hearing (see Article 8.7 of the HMO contract).

C. **Monitoring Access:**

1. **Service Access Areas:** Please explain in detail the State's plans to monitor and improve the following areas of service access:

- a. time and distance

The Network Administrator and HMOs are contractually required to submit a monthly provider file listing the provider network and PCP capacity. The file must identify provider additions and deletions. The State may choose to audit these files periodically by comparing the reported network to a computer generated mapping of the PCCM and HMO's network using geographic information software or similar automated reporting mechanisms.

Whether in the PCCM plan or the HMO model, access is understood as quite complex and inclusive of many more factors than travel-time standards. For example, a client's prior history with an institution might override travel considerations, particularly if that is where a client's PCP practices; geographic barriers such as rivers, highways, mountains, and railroad yards may make it difficult to reach an institution that is nearby on a map; cultural barriers related to neighborhood, language spoken, ethnic mix of staff and/or clientele may make an institution farther away more comfortable than one nearby; public transportation routes often differ from travel in a private car, and are a primary means of travel for

many clients; and, finally, beliefs about the quality of an institution may lead to bypassing one hospital to seek care at another that is farther away. Therefore, the State attempts to the extent practical and possible, to be aware of historic use patterns.

Monitoring access to hospitals in the State's PCCM plan takes into consideration the same factors used by the State under its 1915(b)(4) waiver for selective contracting in the traditional Medicaid program. The selective contracting approach to assuring appropriate access is not based on analysis of travel time.

The Contract between the State and the HMO requires the HMO to have PCPs available throughout the service area to ensure that no client must travel more than 30 miles to access the PCP, unless an exception to this distance or time requirement is made by the TDH. Further, the HMO Contract (See Article 7.10.4 of the HMO Contract) requires that HMOs must ensure that no client is required to travel in excess of 75 miles to secure services with referral providers and speciality services. Exceptions to this provision may occur when an HMO has established, through utilization data provided to TDH, that a normal pattern for securing health care services within an area exists or the HMO is providing care of a higher skill level or specialty than the level which is available within the service area.

The State also examines complaint reports and Member and Provider satisfaction surveys for any trends in access problems that may be associated with time and distance barriers to care or sufficiency of provider network. If problems are identified, corrective action appropriate to the scope of the problem is requested of the Network Administrator and HMO. For example, the State conducted face-to-face meetings with one service area's MCO representatives (in separate meetings) regarding concerns about the THSteps providers capacity. Specific corrective action plans were developed in each case.

- b. waiting times to obtain services, including waiting time for an appointment and waiting time in the office.

Periodic review of the PCCM and HMO's waiting times per QARI Standard XI are part of the annual review of both model's quality improvement program. The Member satisfaction survey, which is administered by the Texas Health Quality Alliance, also contains questions pertaining to waiting times for access to appointments and waiting times in the providers' offices. Results of the monitoring are shared with the Network Administrator and HMOs and corrective action and follow-up requested where indicated.

- c. provider-to-Member ratios

As part of the enrollment functions performed by the Enrollment Broker, PCP capacity will be tracked and reported monthly across all plans to TDH.

- d. denial of referral requests

Denial of referral requests are tracked through review of complaint reports and Member satisfaction surveys. The Network Administrator and HMO are required as part of their Quality Improvement Program to develop systems to clearly document and notify an enrollee of reasons for denial, termination or other limitation of a covered health care service, including information about the PCCM plan's and HMO's complaint and appeal process. (See Article 8.7 of the HMO Contract.)

e. 24-hour accessibility

The Network Administrator conducts quarterly monitoring of the availability and accessibility of PCPs in the PCCM network during regular business hours and after regular business hours. Monitoring includes assessment of compliance by all PCCM PCPs with the phone arrangement requirements stated in Section 3.5 of the PCCM PCP contract. THQA conducts “spot checks” on 24 hour accessibility.

The HMO must require, through contract provisions (see Article 7.8.10 in the HMO Contract), that PCPs are accessible to clients 24 hours a day, 7 days a week. The Contract provides for acceptable and unacceptable phone arrangements for contact PCPs after normal business hours. The HMOs report on their accessibility monitoring in their annual QIP summary reports. In addition, THQA conducts a “spot check” on 24 hour accessibility.

f. Member knowledge of how to appropriately use managed care program

The Quality Monitor (THQA) conducts Member satisfaction surveys annually for a sample of clients who are enrolled presently, and previously for three consecutive months. TDH has adopted the Consumer Assessment of Health Plan Survey (CAHPS). Several of the questions in the survey are designed to measure Members’ understanding of how to appropriately use the managed care program, whether or not they received appropriate materials and Members’ understanding of how to obtain assistance if they have questions or need help in accessing care. The Network Administrator and HMOs are contractually required to develop health education and prevention programs which advise clients on topics including how the system operates and how to obtain services, including emergency services. The Network Administrator and HMOs are also contractually required to include information about how to access services in the Member Handbook.

Member complaint reports and provider satisfaction surveys are also reviewed to identify any areas where client education may need to be addressed. Non-authorized visits to emergency rooms and other providers, as explained below, is also tracked as a measure of client knowledge of how to use the program.

g. Non-authorized visits to emergency rooms, specialists, etc., for medical care.

Use of unauthorized services is tracked through claims review by the Network Administrator and HMOs.

h. Access to emergency or family planning services.

Access to these services is monitored through analysis of utilization data, complaints, and annual Provider and Member satisfaction surveys.

- 2. Procedure for Monitoring:** Beneficiary access to care is monitored as indicated below. Records are maintained to identify lack-of-access trends and for reporting purposes. Check below the monitoring activities that are in effect to assure that beneficiary access to care is not substantially impaired. Also identify the means the State employs to intervene to correct problems. If any of the following differs from the State’s program, please indicate the differences and explain below:

- a. X **An advisory committee** will be designated during the phase-in period to address Member and PCP concerns.

House Bill 2913, from the 75th Legislature, lays out the structure and responsibilities of the Regional Advisory Committees. HHSC and TDH have recently selected the Regional Advisory Committee for the Dallas Service Area. It includes representation from: hospitals, managed care organizations, primary care providers, state agencies, consumer advocates, Medicaid clients, rural providers, long-term providers, specialty providers, including pediatric providers, and political subdivisions with a constitutional or statutory obligation to provide health care to indigent patients (i.e., Hospital District). The first Dallas Regional Advisory Committee meeting was held in January 1999; it is currently meeting on a monthly basis during the roll-out phase of implementation of Medicaid managed care in the Dallas Service Area.

- b. X **A Hotline**
A hotline is maintained by the Enrollment Broker which handles any type of inquiry, complaint, or problem. In addition, the State receives callers through its traditional Medicaid hotline. In July 1999, the State expects to begin operating a statewide toll-free ombudsman line for STAR Members as directed by State legislation.
- c. X **Periodic comparison**
Periodic comparison of the number and types of Medicaid providers before and after the waiver will be conducted. The intent of this review is to identify whether the waiver had reduced access to specific types of providers.
- d. X **Periodic Member surveys** (which will contain questions concerning the Members' access to all services covered under the Waiver) *will be administered on at least a semi-annual basis to a sample of enrollees recertifying for Medicaid eligibility in the TDHS eligibility offices.*
- e. X **PCPs' 24-hour accessibility**
PCPs' 24-hour accessibility is monitored through random calls to PCPs during regular and after office hours by HMOs and by THQA.
- f. X **Other** (explain)

Annual provider satisfaction surveys will be conducted by the Quality Monitor.

- D. Monitoring Quality of Services: Please explain in detail the State's plans to monitor and assure quality of services under the Waiver program. Please describe how will the State monitor the following:

1. **Members' reasons for changing PCPs** in order to detect quality of care problems (not only actual changes, but requests to change specific PCPs);

The Enrollment Broker tracks on a monthly basis the frequency of plan changes. The State is working with the Enrollment Broker to track and trend the reasons for and frequency of plan and PCP changes to identify trends, if any, that may be associated with quality of care problems.

2. **Hotline**

The State will monitor the Network Administrator and HMO hotlines and the hotline staffed by the Enrollment Broker through a variety of mechanisms. For example, the State will place random calls to the lines at various hours of the day and week to ensure their availability. In addition, the State will verify that linguistic requirements, such as Spanish speaking individuals are being maintained. The HMOs submit reports concerning wait times to ensure accessibility.

3. **Periodic Member surveys** (which question the quality of services received under the Waiver) are mailed to a sample of enrollees;

The State, through THQA, conducts Member satisfaction surveys annually for a sample of clients through a mailout and follow up telephone calls. The survey questions are designed to measure client perception of access to services and quality of care. The State's current satisfaction survey, Consumer Assessment of Health Plan Survey(CAHPS), is attached as Appendix IV.D.3.

4. **Complaints**, and appeals system;

The complaint process requirements apply to all participating plans. Written policies and procedures for the receipt, handling and disposition of complaints must be submitted to the State for prior written approval. The Network Administrator and HMOs are required to submit quarterly reports of Medicaid enrollee complaints to the State. The State, through its Enrollment Broker, operates a toll-free Member hotline and clients have access to the State's Medicaid hotline. In July 1999, TDH is expected to begin operating a statewide ombudsman line for STAR enrollees.

5. **Other** (explain).

To assure quality of health care services in this waiver program with respect to HMO contractors, the State's Medicaid agency shall:

Clinical Indicators: List the clinical indicators that the State uses to measure enhanced Quality Assurance activities under the waiver program. HCFA requires that the State conduct focused evaluations on ***each of*** the following clinical areas:

- (1) prenatal care and birth outcomes,

HMOs conduct a pregnancy focused study and collects data annually through medical chart reviews. In the PCCM plan, the State or its designee conducts the same focused study. In both cases, data is based on a random sample of Medicaid enrollees who delivered single or multiple live or stillborn fetuses of greater than or equal to 20 weeks gestation and who were enrolled with the plan continuously for 42 days after delivery.

Clinical indicators include:

- First prenatal visit in first, second or third trimester;*
- Member seen on or before 30 days after enrollment;*
- Number of teen mothers 17 years or younger*

- *Pregnancy Outcomes:*
 - *Maternal deaths*
 - *Still births*
 - *Live births*
 - *Neonatal deaths*
- *Whether or not a postpartum visit was provided within six weeks of the delivery date.*

(2) childhood immunizations,

The HMOs conduct a well child focused study which includes immunization status. In the PCCM plan, the State or its designee conducts the same focused study. In both cases, data is collected annually through medical chart reviews. Data is based on a random sample of Medicaid enrollees who reached the age of 27 months at anytime during the reporting period and were enrolled with the plan continuously for six (6) months.

Clinical indicators include:

- *The rates of receipt of all recommended immunizations against polio (OPV), diphtheria-tetanus-pertussis (DTP), measles-mumps-rubella (MMR), hemophilus influenza B (HIB), and hepatitis B (HBV) in the first 27 months of life;*
- *the rate of receipt of all components of EPSDT screens in the first 27 months of life;*
- *the number of well child check-ups;*
- *the number of EPSDT visits for the sample population during the reporting period; and*
- *the number of lead screens and lead screen levels.*

(3) pediatric asthma, and

HMOs conduct a childhood asthma focused study. In the PCCM plan, the State or its designee conducts the same focused study. In both cases, a random sample is based on all enrollees with a diagnosis triggered by a claim with a primary or secondary (2nd to 5th D/X) diagnosis code of 493.xx (asthma) and six (6) months of continuous eligibility. The child must be age two to nineteen years during the reporting period.

Clinical indicators:

- *Clients with asthma-related emergency room visits, and inpatient admissions; and*
- *Clients with PCP visit following asthma-related emergency room visit; and*
- *educational/preventative services for asthma.*

(4) one clinical indicator pertaining to, if applicable, the Supplemental Security Income

population, or one other indicator pertaining to the covered populations.

The two behavioral health studies that are conducted in the STAR program will be deferred to NorthSTAR to conduct and oversee: (1) substance abuse in pregnancy and (2) ADHD.

Explain how the State included accommodations to monitor special populations; e.g., SSI. Describe how the State collects, analyzes and provides summary data to HCFA on an annual basis. Also describe how these were and will be used for continuous quality improvement in the waiver program.

The Network Administrator and HMOs are required to develop a system (for HMO model see Article 6.13.2 of the HMO Contract) for identifying clients with disabilities or chronic or complex conditions and ensuring that appropriate plans of care for this population are developed and monitored. Assessment of the Network Administrator and HMOs on this requirement will occur as part of Texas Health Quality Alliance's and HMO's on-site review conducted by THQA and annual administrative audits of the Network Administrator's and HMO's Quality Improvement Programs. This data will be used in the QIP process to identify under- and over-utilization of services and other quality of care concerns.

E. Quality of Services were further monitored through the mechanisms outlined. Quality of services problems identified will result in a desk review or an onsite medical review to resolve the problems.

F. Services Not Included: Please identify any services not included under the waiver program below. Describe how the services not covered under the waiver (i.e., services not restricted) are obtained under the regular Medicaid program, and how beneficiaries were informed of these services and the process for obtaining such services. Include any expected changes for the renewal period.

PCCM Plan:

EPSDT medical screens are not restricted and the client may obtain the services from any Medicaid participating EPSDT provider.

The Network Administrator is contractually required to ensure that Medicaid enrollees receive proper information regarding covered EPSDT services (i.e. scope and periodicity) and to develop mechanisms to ensure that eligible newly enrolled clients receive an EPSDT medical screen within 90 days of enrollment if a screen is required by the periodicity schedule in the Medicaid Provider Procedures Manual, and if the client is eligible for the screen, unless the client knowingly and voluntarily declines or refuses services. The Network Administrator must also arrange for training for its network health care providers and the providers' staff about the EPSDT program requirements relevant to their responsibilities and assure that clients do not experience unreasonable delays in the scheduling of EPSDT appointments, delay in waiting for EPSDT appointments at the office, or excessive travel times and distances.

As noted above, EPSDT services, including lead screening and immunizations are part of a well child focused study. Data is also collected and monitored through utilization reporting. PCPs in the State's PCCM plan are also required to report through TDH's ImmTrac program. The ImmTrac program is a tracking system that centralizes data on immunizations furnished and billed by any provider within the State of Texas for all Texas children. The intent was for PCPs, parents, providers, and public health clinics will be able

to call and get the latest immunization information using an automated voice response system. However, legislation two years ago changed one utility of this data, by requiring parental consent for immunization data to be placed in the ImmTrac system.

Family planning services are also a nonrestricted preventive service. Utilization of these services will be tracked through utilization management reporting.

HMO Model:

The HMO is not responsible for providing non-STAR services such as EPSDT dental, ECI case management and other targeted case management programs, but the HMO is responsible for appropriate referrals for these services. Information about these services is provided in Member Handbooks and other communication from HMOs to Members.

- G. Periodic reviews:** Please describe the areas covered in the State's periodic reviews of claims files and medical audits, including the types of care reviewed and how the problems were resolved. Please include how often these reviews took place, and will continue during the renewal period.

PCCM Plan:

During the first year of Member enrollment, the plans will submit a baseline medical record audit of their providers, based on the requirements found in Standard XII of QARI. The State or its designee will perform and submit two subsequent quarterly medical record audits in the Texas Health Network Program. In instances in which audits reveal noncompliance, the Network Administrator shall submit a plan for corrective action and a timetable for achieving compliance. Included in the annual reports of QIP activities will be the corrective actions undertaken as a result of the medical record audits and improvements achieved.

The State will examine physician profiles in the PCCM plan on a periodic basis.

Under- and over-utilization also will be assessed during the medical record audits, and at the annual administrative audit of the plans identified problems will be resolved by the Network Administrator implementing corrective action plans, and/or education of providers and provider staff, and performing follow up monitoring to ensure that corrective action plans have been implemented and that corrective action is effective.

The plans also will submit emergency services data reports on a quarterly basis. The types of care that will be reviewed include the total number of ER encounters/1,000, and the top five diagnosis by ICD-9 code reported as a percentage of total number of encounters for the largest hospitals.

HMO Model:

During the first year of Member enrollment, the HMOs will submit a baseline medical record audit of their providers, based on the requirements found in Standard XII of QARI. The State or its designee will perform and submit two subsequent quarterly medical record audits. In instances in which audits reveal noncompliance, the HMO shall submit a plan for corrective action and a timetable for achieving compliance. Included in the annual reports of QIP activities will be the corrective actions undertaken as a result of the medical record audits and improvements achieved.

The State will examine physician profiles of the HMOs on a periodic basis.

Under- and over-utilization also will be assessed during the medical record audits, and at

the annual administrative audit of the HMO's identified problems will be resolved by the HMO implementing corrective action plans, and/or education of providers and provider staff, and performing follow up monitoring to ensure that corrective action plans have been implemented and that corrective action is effective.

The HMOs also will submit emergency services data reports on a quarterly basis. The types of care that will be reviewed include the total number of ER encounters/1,000, and the top five diagnosis by ICD-9 code reported as a percentage of total number of encounters for the largest hospitals.

In addition explain how these reviews will determine:

- (1) the appropriateness of treatment was consistent with diagnosis;

Medical record audits include assessment of the appropriateness of treatment compared to the diagnoses.

- (2) appropriate treatment and outcomes resulted for participants with certain high risk chronic or acute conditions (e.g., asthma, hypertension, diabetes, otitis media, lead toxicity, drug dependency, diseases preventable by routine immunization);

Utilization management reporting, medical record audits, and specific outcomes measured through focused studies will be examined relative to benchmarks, historical trends, and nationally recognized practice parameters/care guidelines to assess plan accomplishments with respect to appropriate treatment and outcomes for this population.

- (3) services provided emphasized preventive care and resulted in early detection;

Through medical record audits, utilization management reports and claims data, and through annual assessment of the plans' health education programs, the State is able to track EPSDT and other preventive services, prenatal care, and family planning.

- (4) PCP appropriately referred Members for specialty care; and
The instrument that will be used to audit medical records will include assessment of the appropriateness of referrals. Indirect measures of appropriateness of referrals may be identified through analysis of data as reported through utilization management reporting, review of Member complaints, Member satisfaction surveys, and the annual MCO on-site review of the plan.

H. State Intervention: If a problem is identified regarding access to care and quality of services problems, the State intervenes as noted below (please indicate if the State's program differs and explain).

- Education and informal mailings to beneficiaries and providers;
- Telephone and/or mail inquiries and follow-up;
- Request HMO and/or PCP response to identified problems;
- Referred to program staff for further investigation;

- Warning letters;
- Refer to State's medical staff for investigation;
- Corrective action plans and follow-up;
- Change a beneficiary's PCP;
- Restriction on types of beneficiaries;
- Further limit the number of assignments;
- Ban new assignments;
- Transfer some or all assignments to different HMOs or PCPs;
- Suspend or terminate HMOs;
- Suspend or terminate as Medicaid providers; and
- Other (explain):

HMO sanctions as described in Article 18 of the HMO Contract.

Explanation: Any or all of the above interventions may be used by the State in the PCCM and HMO models, as appropriate to the scope and severity of the problem(s) identified through routine monitoring of access to care and quality of care, complaints, and Member and provider satisfaction surveys.

1. In addition, for all HMOs, the State will arrange for an independent, external review of the quality of services delivered under each managed care organization's contract with the State. The review will be conducted for each HMO contractor on an annual basis. The entity/ies which will provide the annual external quality reviews is/are not a part of the State government, and is/are not (a) managed care organization(s) or (an) association of managed care organization(s). The entity/ies is/are:
 - a. ____ A Peer Review Organization (PRO). Specify the name of the PRO:
 - b. X A private accreditation organization approved by HCFA. Specify:
JCAHO; DBA Texas Health Quality Alliance
 - c. ____ A Pro-Like entity approved by HCFA. Specify:
2. Member access to care will be monitored as part of each plan's internal QIP and through the annual external quality review. The State will include the following activities as part of the external quality review or State monitoring activities. Check any that apply.
 - a. X Periodic comparison of the number and types of Medicaid providers before and after the Waiver.

- b. ☒ Periodic Member surveys which contain questions concerning Member access to services.
 - c. ☒ Measurement of waiting periods to obtain health care services indirectly through Member satisfaction surveys, review of hotline logs and complaint reports, and audit of HMO's access monitoring per QIP standards in HMO contract.
 - d. ☒ Measurement of referral rates to specialists.
 - e. ☒ Assessment of Member knowledge about how to obtain health care services through analysis of Member satisfaction surveys, provider satisfaction surveys, complaint reports, and claims denial analysis.
 - f. ☒ Measurement of access to services during and after a plan's regular office hours, e.g., through random phone calls to plans.
 - g. ☒ Measurement of access to emergency or family planning services through review of utilization management data/reports, complaints, and Member satisfaction surveys.
 - h. ☒ Measurement of Member requests for disenrollment from a plan.
 - i. ☒ Other indicators. Specify: *Assessment of access issues which may be identified through routine review of PCP and plan change reports, Member hotline logs, and quarterly complaint reports, provider satisfaction surveys, and administrative audits of HMO contractual obligations related to access not specifically identified above. See HMO contract.*
3. In addition to the above processes, the proposed Waiver program is not likely to substantially impair access to services because of the following. Check all that apply:
- a. ☒ Members may choose any of the participating plans in the Waiver area as his/her managed care plan. In addition, as per 42 CFR 434.29, within a plan, each Medicaid enrollee has a choice of health professionals to the extent possible and feasible.
 - b. ☒ The same range and amount of services that are available under the non-waivered Medicaid program are available for Waiver enrollees. (See also Appendix II.G.b. for identification of enhanced benefits for managed care enrollees.)

- c. X Distances and travel time to obtain services for Members under the Waiver will not substantially change from that of the non-waivered Medicaid program.
- d. X The number of providers to participate under the Waiver compared to before the Waiver is expected to remain the same or increase or the capacity of the providers will remain the same or increase.
- e. X Primary care and health education are provided to enrollees by a chosen or assigned plan. This fosters continuity of care and improved provider/patient relationships.
- f. X Preauthorization is precluded for emergency and family planning services under the Waiver.
- g. X Members have the right to change plans if the arrangement is not satisfactory.
- h. X Plans are required to provide or arrange for coverage 24 hours a day, 7 days a week.
- i. X The same complaint system which was in effect under the regular Medicaid program will be in effect under the waiver program. Members have available a formal appeals process under 42 CFR Part 431, Subpart E.
- j. X In addition to the complaint system specified in paragraph i. above, the plans have their own systems for handling complaints.
- k. Other. Specify:

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CHIP Annual Report
Detail for FY 1999 - Table 4.1.1

FY 1999

Quarter 1 Quarter 2 Quarter 3 Quarter 4 Total

1. Undup # ever enrolled						
A. Fee for service	33938	36733	35135	32321	138127	
B. Man car arrg	2267	2638	2006	1845	8756	
C. PCCM	873	987	777	814	3451	
2. Undup # new enrolles						
A. Fee for service	11081	5732	3940	3714	24467	
B. Man car arrg	8	0	0	1	9	
C. PCCM	4	1	2	1	8	
3. Undup # disenrollees						
A. Fee for service	1820	3583	3940	4180	13523	***
B. Man car arrg	253	1023	1132	1028	3436	***
C. PCCM	106	393	418	411	1328	18287 ***
4. # Member mths enrolmt						
A. Fee for service	89878	99603	96538	87683	373702	
B. Man car arrg	6399	6314	4330	3957	21000	
C. PCCM	2426	2380	1725	1804	8335	403037
5. Avg # months (L#4/#1)						
A. Fee for service	2.6	2.7	2.7	2.7	2.705496	8.474545 **
B. Man car arrg	2.8	2.4	2.2	2.1	2.398355	4.346026 **
C. PCCM	2.8	2.4	2.2	2.2	2.415242	4.276552 **
						7.921636 **
Annual Numbers						
6. Undup # ever enroll						
A. Fee for service				44097 *		
B. Man car arrg				4832 *		
C. PCCM				1949 *		
				50878 *		

*Annual number ever enrolled: numbers taken from 4th quarter annual numbers

**average # of months enrollment: sum of quarterly months enrolled/annual unduplicated ever enrolled

***# disenrollees: sum of quarterly disenrollees

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CHIP Annual Report for FFY 99

Table 4.1.1. CHIP Program Type: Medicaid Expansion to U3s

Characteristics	Number of Children Ever Enrolled		Average Number of Months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children						
Age						
Under 1						
1-5						
6-12						
13-18	25,176	50,878	2.2	7.9	370	18,287
Countable Income Level*						
At or below 150% FPL	25,176	50,878	2.2	7.9	370	18,287
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						
13-18						
At or below 150% FPL	25,176	50,878	2.2	7.9	370	18,287
Above 150% FPL						
Type of Plan						
Fee-for-Service	22,677	44,097	2.1	8.5	370	13,523
Managed Care	1,780	4,832	2.4	4.3		3,436
PCCM	719	1,949	2.5	4.3		1,328

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CHIP Annual Report
Detail for FY 1999 - Table 4.3.1

	FY 1998 Quarter 4		FY 1999 Quarter 1			Quarter 2
	Total	Federal	Total	Federal	Total	Total
Total expenditures	1732882	1275400	9425735	6948652	1410308	1410308
Premiums for private health insurance (net of cost-sharing offsets)*	1395320	1026955	6242201	4601751	927378	927378
Fee-for-service expenditures (subtotal)	337562	248445	3183534	2346901	482929	482929
Inpatient hospital services						
Inpatient mental health facility services						103694
Nursing care services						
Physician and surgical services						
Outpatient hospital services						
Outpatient mental health facility services						
Prescribed drugs	336362	247562	1134645	836460	155765	155765
Dental services			1724683	1271436	175278	175278
Vision services						
Other practitioners' services						
Clinic services						
Therapy and rehabilitation services			58340	43008	11150	11150
Laboratory and radiological services						
Durable and disposable medical equipment						
Family planning						
Abortions						
Screening services			155865	114904	15468	15468
Home health						
Home and community-based services						
Hospice						
Medical transportation						
Case management	1200	883	27791	20488	4715	4715
Other services			82210	60605	16858	16858

25-Jan-00		CHIP Annual Report for FFY 99			
		Table 4.3.1. CHIP Program Type: Medicaid Expansion to U3s			
Type of Expenditure		Total computable share		Total federal share	
		FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		1,732,882	46,992,534	1,275,400	34,642,58
Premiums for private health insurance (net of cost-sharing offsets)*		1,395,320	31,735,500	1,026,955	23,395,41
Fee-for-service expenditures (subtotal)		337,562	15,257,034	248,445	11,247,17
Inpatient hospital services					
Inpatient mental health					
facility services		0	1,835,380	0	1,352,78
Nursing care services					
Physician and surgical services					
Outpatient hospital services					
Outpatient mental health					
facility services					
Prescribed drugs		336,362	5,264,358	247,562	3,880,88
Dental services		0	6,382,405	0	4,705,10
Vision services					
Other practitioners' services					
Clinic services					
Therapy and rehabilitation services		0	439,227	0	323,79
Laboratory and radiological services					
Durable and disposable medical					
equipment					
Family planning					
Abortions					
Screening services		0	503,158	0	370,92
Home health					
Home and community-based services					
Hospice					
Medical transportation					
Case management		1,200	222,661	883	164,14
Other services			609,845		449,53

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**CHIP Annual Report
Detail for FY 1999 - Table 4.3.2**

	FFY 1998	FFY 1999 Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Total computable share						
Outreach						
Administration	45246	3241982	4085785	3354509	-5459823	5222453
Other						
<hr/>						
Federal share						
Outreach						
Administration	33301	2388261	3012041	2472943	-4024982	3848263
Other						

all values based on submitted quarterly HCFA 21s

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**CHIP Annual Report for FFY 99
Table 4.3.2. CHIP Program Type: Medicaid Expansion to U3s**

Type of Expenditure	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHI FFY 1998
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	
Total computable share					
Outreach					
Administration	45,246	5,222,453			
Other					
<hr/>					
Federal share					
Outreach					
Administration	33,301	3,848,263			
Other					

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**CHIP Annual Report
Detail for FY 1999 - Table 4.3.2**

	FFY 1998	FFY 1999	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Total computable share							
Outreach							
Administration	45246		3241982	4085785	3354509	-5459823	5222453
Other							
<hr/>							
Federal share							
Outreach							
Administration	33301		2388261	3012041	2472943	-4024982	3848263
Other							

all values based on submitted quarterly HCFA 21s

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CHIP Annual Report for FFY 99

Table 4.3.2. CHIP Program Type: Medicaid Expansion to U3s

Type of Expenditure	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHI
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	
Total computable share					
Outreach					
Administration	45,246	5,222,453			
Other					
Federal share					
Outreach					
Administration	33,301	3,848,263			
Other					